

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049523
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12723

FILED JAN 16 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		d. STREET ADDRESS (If outside, give location) 1210 FRANKLIN	
3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD GRIFFITH		4. DATE OF DEATH Month Day Year DEC. 17 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/23/93
10a. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (last birthday) 68
11a. BIRTHPLACE (City and state or country) IND		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME FRANK		13b. MOTHER'S MAIDEN NAME MAUDE HARLAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT C.R. Grubb 707 Clark Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO (b) Generalized Arterio sclerosis DUE TO (c) 331X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hypertrophy		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 12-11-62 to 12-17-62 and last saw her alive on 12-17-62 Death occurred at 12:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ross Dues B. Lader, M.D.		22b. ADDRESS 1515 LAFAYETTE AVENUE	
22c. DATE SIGNED 12-17-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-7-1962	23c. NAME OF CEMETERY OR CREMATORY St. Matthews	23d. LOCATION (City, town, or county) St. Louis, Mo.
25. DATE RECD. BY LOCAL REG. JAN 4 1963		REGISTRAR'S SIGNATURE Road Smith, M.D.	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

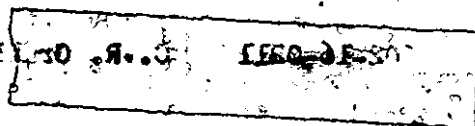
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BLADES
USE BLACK INK
OR
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VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Fred J. Farmer

Licensed Embalmer No. 4788

P. O. Address St Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.